HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
AUTHORIZED LEAVE OF ABSENCE WITHOUT PAY

Employee's Name (Last, First, M.I.) & Address	**Social Security No.**
	Dates of authorized leave of absence without pay **From:** **To:**

Monthly Employee Contributions	
Medical, Drug, Chiropractic	$_____
Dental	_____
Vision	_____
Total	$_____

As long as you are on an authorized leave of absence without pay, your employer will continue to pay their share of contributions for health benefits and they will continue to pay in full your life insurance plan benefits.

At your option, you may (1) voluntarily cancel your health benefit plan enrollments (you will need to complete an EC-1 form) and re-enroll in the same benefit plans upon return to work or (2) continue your enrollments during your leave by paying the following premiums:

1st payment:

$_____ on or before _____1, 200____ and,

Subsequent payments:

$_____ on or before the 1st of each succeeding month until you return to an active pay status. You may send multiple monthly payments in advance of your payment due dates. Make checks payable to "EUTF" and be sure to indicate your SS# and applicable month(s) on your check. Send your payments to:

EUTF
P.O. Box 2121
Honolulu, Hawaii 96805-2121

NOTE: Failure to pay your premiums may result in administrative cancellation of health plans. If your enrollments are cancelled by the EUTF during your leave due to non-payment of premiums, you may re-enroll in the same benefit plans upon return to work.

For DPO USE:

Employer _____ Agency/Department _____

DPO Signature _____ Date _____ Phone _____

For DPOs: Fax the completed form to EUTF at 808-586-2161 and make a copy for the employee.